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ABSTRACT

This speech, presented at the "Symposium for the Advancement of Non-Aversive Behavioral Management" by the counselor to the Attorney General and Assistant Attorney General from the U.S. Department of Justice, supports the view that use of aversive procedures on institutionalized severely handicapped individuals is inappropriate. The 14th amendment of the U.S. Constitution guarantees safe living conditions and freedom from unnecessary bodily restraints, and may be violated when aversive stimuli are used. The deference accorded by the court system to professionals caring for institutionalized persons should be challenged when professional judgments are not "presumptively valid," for instance, when institutionalized persons are treated in a manner repugnant to decency norms. The research literature has shown that aversive conditioning has only short-term results, that positive interventions may produce better long-term effects, and that negative side-effects result from aversive interventions. Parental consent to aversive conditioning may be legally defective as parents are sometimes not given full information concerning treatment options. The Civil Rights Division of the U.S. Department of Justice vows to examine vigorously the use of aversive techniques under the Civil Rights of Institutionalized Persons Act and to act swiftly when violations are found. (JDD)

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Department of Justice

ADDRESS

OF

WM. BRADFORD REYNOLDS
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& ASSISTANT ATTORNEY GENERAL

AT

THE

COMMUNITY SERVICES FOR AUTISTIC ADULTS AND
CHILDREN'S ANNUAL SYMPOSIUM FOR THE ADVANCEMENT
OF NON-AVERSIVE BEHAVIORAL TECHNOLOGY

HOLIDAY INN
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It is a distinct pleasure to have been invited by the Community Services for Autistic Adults and Children to participate in this symposium on the "Advancement of Nonaversive Behavioral Management."

A number of you here today are concerned, as am I, with what appears to be increasing use of aversive procedures on individuals with severe handicaps in institutionalized settings. Such "treatment" raises serious questions about our vision of civilized society, as well as posing constitutional issues of a fundamental nature. I am delighted to see this conference focusing attention on this vexing and troubling issue from the perspective of those who live too often with pain and discomfort and receive too little recognition of their human worth and dignity.

Let me emphasize up front that I have neither the inclination nor the expertise to speak definitively about behavior modification techniques in institutionalized settings. Certain such techniques are widely accepted and routinely applied, and very little controversy surrounds them. Experience in the Civil Rights Division, gained in connection with investigations of mental health and mental retardation facilities pursuant to the Civil Rights For Institutionalized Persons Act (CRIPA), has demonstrated for me the appropriateness of various techniques which have both a positive and humane focus. I have in mind specifically methods of "positive reinforcement," for

example, where appropriate behavior is rewarded by giving an individual praise, attention, food, or other affirmative stimulus -- a technique that has resulted in the repetition and ultimate strengthening of desirable behavior. In addition, and frequently in conjunction with that approach, there is the flip-side of that coin, where, in order to discourage maladaptive behavior, no response is given to undesirable conduct. If done consistently and deliberatively, failure to reward or reinforce unwanted behavior can over time help measurably to eliminate it entirely, or at the very least greatly reduce its reoccurence.

As I stated, these are appropriate techniques. Aversive conditioning fits neither treatment mode, and from my vantage point as the principal law enforcement official under CRIPA, it is disturbingly inappropriate in many of its manifestations. The core philosophy underlying the use of aversive stimuli is, from my perspective, highly suspect. It rests on the basic assumption that the way to reduce or eliminate undesirable behavior patterns is by causing a person to associate a terribly unpleasant, and usually painful, experience with the behavior in question. As you all know full well, this unpleasant, painful experience is called the aversive stimuli, the "punisher," or the "negative reinforcer."

A startling array of aversive stimuli are in use today: electric shock treatments; noxious odors or flavors (ammonia

capsules under the nose, Tabasco sauce, vinegar, lemon juice, and even shaving cream in the mouth); loud noises or "white noise"; bodily shaking; pinching (including fingernail pinching that breaks the skin); spraying water in the face and cold showers and baths; face screening (covering the person's face with a cloth bib or bag); and certain kinds of physical restraints. It is the use of such techniques -- under camouflage of the softened phraseology "aversive conditioning" -- that needs more careful scrutiny and more public examination as a so-called "treatment" that by design and in fact inflicts physical pain on so many persons with severe handicaps in institutionalized settings.

I am, of course, not the first to sound this note. Use of aversive stimuli have given rise to a number of troublesome allegations of abuse, and even torture. Questions have regularly and legitimately been raised whether such techniques should be used regardless of their efficacy in treatment or training, especially when the more extreme procedures are involved.

On strictly legal grounds, constitutional concerns are invariably suggested by use of a painful stimulus on a nonconsenting adult or child who has been institutionalized and has demonstrated responsiveness to nonaversive treatment. Without getting overly technical, the fourteenth amendment protects all individuals against the denial, by State action, of life, liberty, or property without due process of law. As the

Supreme Court recently recognized in Youngberg v. Romeo, 457 U.S. 315 (1982), any person who is committed to the custody of a State has a constitutionally protected liberty interest in, at the very least, receiving adequate food, shelter and clothing -- and adequate medical treatment. The person also has a liberty interest, the Court held, in having safe living conditions and freedom from unnecesary bodily restraints. Given the physically abusive (and even, in some instances, barbaric) nature of some aversive stimuli, it cannot be denied that these constitutional principles may in certain circumstances be implicated.

I will spare all of you the tedium of sitting through the development of a legal brief on the subject. But certain general observations deserve mention in order to frame a more reasoned debate in this area. For starters, the Supreme Court has told us that in matters dealing with the care and treatment of institutionalized persons a considerable degree of deference should be accorded the judgment exercised by qualified professionals. Thus, professional judgment is regarded by the Court as "presumptively valid"; it is vulnerable to serious constitutional challenge only if and "when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." (457 at 323).

It is high time, I think, that the challenge be made in the public arena to those who profess that the use of aversives -- at least those calculated to control behavior through the regular infliction of painful stimuli -- actually have presumptive validity under this standard. I am neither a psychiatrist, psychologist, physician nor otherwise of the medical profession. As a legal craftsman, I admittedly bring no special expertise to this subject. Yet, common sense tells me that we have advanced well beyond that primitive state where electric shock techniques might have been regarded as an "acceptable" measure of behavior-control. The behavioral scientist Pavlov became famous for using such a technique to control the bark and bite of his dog. But, persons confined to mental or penal institutions do not, by virtue of that fact, lose their humanity or deserve the treatment of Pavlov's dog.

Institutionalized persons are, after all, human beings, with a dignity and personality that are entitled to cultivation, not debilitation. In a very real sense, this is our most vulnerable population. These individuals are almost never heard when they "cry out"; their parents too often have only limited audiences, and funding always seems hard to obtain. But none of these realities justify treating mentally retarded or autistic individuals in a manner wholly repugnant to decency-norms. We do not, for example, tolerate electric shock treatment in our prisons; we long ago insisted that cattle prods not be used on

people; and we would, I am confident, decry the intentional infliction of pain in the classroom as a behavior stimulus to bring into line undisciplined students. All such techniques -- as well as those I catalogued a few minutes ago -- fall well outside the bounds of acceptable professional judgment when discussed in connection with the population at large. No reasoned basis has yet been offered, to my knowledge, for a different response inside the mental institution.

In this regard, I need none of the medical degrees I lack to make the general observation that the research literature pertaining to the use of aversives is in a sorry state of disarray. Indeed, recent works in behavioral psychology indicate that positive interventions may well produce better effects, over the long term and in more situations, than aversive interventions. There are also studies showing some extremely negative side-effects to aversive interventions concerning the physical, emotional, and interpersonal relationships of persons subject to such "treatment." In fact, not infrequently, these side-effects are more drastic than the behavior that was originally to be eliminated. And, even where it can be shown that the aversive "treatment" produced modest short-term results, those behavorial modifications invariably disappear once the negative stimuli are removed.

In short, the serious question to be asked is on what professional footing now stands the use of pain-inflicting aversive treatment techniques? Only a few weeks ago, we read in the area newspapers of a study professing to show that autistic children responded positively to shock treatments. Perhaps so. But the sample on which the study was based was a grand total of two children, neither of which showed any inclinatior to continue the modified behavior once the negative stimulus was removed. So much for presumptive validity.

There are, of course, other concerns that can be raised, concerns that relate, for example, to the whole question of parental consent. Judicial precedent requires that an individual who is to be subject to aversive treatment, or his or her guardian, must consent to the treatment. This person must have the capacity to consent, must receive sufficient information regarding the treatment, and, when he or she determines to give or withold consent, must do so voluntarily. Based on our experience under CRIPA, there is strong reason to doubt that parents and guardians who are authorized to give consent for aversive treatments receive full information concerning options for treatment, including the consequences of all potential treatments. This may well render the parental consent, if given, legally defective. Obviously, that is another matter worth probing.

But, I have dwelled too long on legal niceties. This conference should not be preoccupied with the intricacies of constitutional analysis. The basic question, in this area is not merely whether aversive techniques pass constitutional muster. At a more basic level the issue is whether aversive techniques, particularly at their most extreme, pass a more fundamental test: whether they are so cruel, so dehumanizing and abusive, so shocking to the conscience of a civilized society, that they are unacceptable as a treatment mode, even if, contrary to conventional wisdom, they should someday prove to be efficacious. The Association for Persons with Severe Handicaps (TASH) reached such a conclusion in its 1981 resolution calling for the cessation of aversive procedures. Other groups, the Association for Retarded Citizens, the American Association on Mental Deficiency, and the Council on Exceptional Children, have also called for severe restrictions on the use of aversive interventions.

The debate on this subject must continue. This symposium has, among other things, served a most useful purpose by helping to plant the seeds of doubt -- both in policy and legal terms -- on continued use of aversive stimuli. We in the Civil Rights Division still have serious misgiving about the validity of such procedures, no matter how benevolently devised, when these procedures are designed to inflict pain and discomfort on persons with severe handicaps in institutionalized settings. We intend

to examine vigorously the use of these techniques in our reviews under the Civil Rights of Institutionalized Persons Act and to act swiftly when we find violations of the law.

We further pledge to continue this dialogue with you and other groups on this crucial and troubling issue. There may be developed some day a body of professional opinion that can provide a learned and reasoned basis, under some special circumstances and in certain controlled environments, for limited use of some modest aversive stimuli to treat certain mentally handicapped individuals. That case has not yet been made, however, and I, for one, remain skeptical. Whatever claim can be made for behavior modification as a result of pain-inflicting aversive techniques, I am persuaded today that it can be more than matched by use of "positive reinforcements" -- and with more lasting consequences. If I am wrong, it seems quite clear to me that in the civilized society in which we live, the burden must be on those arguing the contrary position, and it should weigh heavily. I leave to each of you the challenge to force such advocates of aversive intervention to meet that burden before they administer their so-called cure.

Thank you.